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TECHNICAL REPORT:

Assessment of Gynecologists' Reproductive Health Training Needs in Ferghana Oblast

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Tashkent, Uzbekistan

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I. Abbreviations

AIDS	Acquired immune deficiency syndrome
COC	Combined oral contraceptives
GP	General practitioner
HIV	Human immunodeficiency virus
IUD	Intrauterine device
NFP	Natural family planning
NGO	Nongovernmental organization
Ob-gyn	Obstetrician-gynecologist
PHC	Primary healthcare
POC	Progestin-only contraceptives
RH	Reproductive health
STD	Sexually transmitted diseases
SVP	Selskiye vrachebniye punkt (rural medical post)
USAID	United States Agency for International Development
UZMPA	Uzbekistan Medical and Pedagogical Association
VSS	Voluntary surgical sterilization

II. Introduction

The ZdravPlus project, funded by the US Agency for International Development (USAID), is working with the Government of Uzbekistan to improve the quality and efficiency of health services. The project works in Ferghana Oblast to support health sector reform as well as training, limited provision of equipment and strengthened management of primary health care services through 'selskiye vrachebniye punkty' (SVPs or rural medical posts).

ZdravPlus supports the government's efforts to introduce General Practitioners (GPs) by preparing the large cadre of specialists working at the primary health care (PHC) level to provide a broader range of basic health care services. Training in reproductive health (RH)* is an important priority for the project and RH training for pediatricians, internists, nurses and midwives is ongoing. However, obstetrician-gynecologists (ob-gyns) continue to play a major role in providing RH services and it has become clear in recent months that many of them are unfamiliar with modern international approaches to RH.

The purpose of this assessment was to obtain some general information on the extent to which ob-gyns have had RH training in recent years, their knowledge of, and attitudes toward, current international approaches to the provision of contraception and their perceived training needs. The results are being used to modify existing training curricula to better meet their needs, before ZdravPlus embarks on large-scale training of ob-gyns in Ferghana Oblast.

III. Assessment Methodology

The assessment was conducted in Akhunbabaev, Ferghana, Kuvasay and Oltiarik Rayons in Ferghana Oblast on March 12 and 13, 2002. It was undertaken jointly by the Uzbekistan Medical and Pedagogical Association (UZMPA), an Uzbek NGO that provides RH training, and ZdravPlus. Both parties collaborated in the development of the assessment instruments; UZMPA conducted the assessment; and both parties analyzed the data and prepared this report.

At the request of *ZdravPlus* staff, coordinators from the four rayons invited gynecologists who work at the PHC level to participate in the assessment when they came to the rayon center for a regular meeting. Twenty-six gynecologists participated in the assessment—about 60 percent of all gynecologists in these four rayons. The following table shows the number of participants, by rayon.

Table 1: Number of Ob-gyns Participating in the Assessment, by Rayon

Rayon	No. Of Ob-gyns
Kuvasay	8
Ferghana	3
Akhunbabaev	5
Otilarik	10
Total	**26**

The assessment consisted of two parts:

- Focus group discussions – one in each of the four rayons – aimed at ascertaining the gynecologists' attitudes toward modern approaches to providing RH services as well as their needs and desires in terms of the knowledge and skills they think they need. (The discussion guide appears as Annex 1.).

* In Uzbekistan family planning is officially referred to as reproductive health. Accordingly, the term reproductive health is used in this document, although the needs assessment was centered on family planning issues.

- A multiple-choice questionnaire, based on the pre- and post-test used during training for gynecologists, sought to identify providers' level of knowledge and skills on key aspects of service provision. (The questionnaire is included as Annex 2).

It should be noted that the assessment was intended to gather information quickly as a prelude to a new round of training. The sample was not scientific, the tools were not carefully refined and the methodology was not meticulous. Accordingly, the results should be interpreted with caution.

IV. Findings

A. Results of the Focus Groups

1. General Information

As can be seen from the table below, 20 out of the 26 gynecologists who participated in the focus groups – about three-quarters – had not had any RH training in recent years. About one in four had attended a course on modern contraception or hormonal contraceptives, but none had received training in modern techniques of IUD insertion. In an environment where IUDs dominate, the method-mix and the no-touch technique of insertion has not traditionally been practiced, this is of concern.

Table 2: Ob-gyns' Participation in Reproductive Health Training (N = 26)

No. of Gynecologists	Course Organizer	Duration of Course
Twenty	No training	N/A
Three	ZdravPlus with UZMPA trainers	5 days
One	Andijan Medical Institute	5 days
One	Shering Company	3 days
One	Andijan Medical Institute	1 day

The ob-gyns expressed interest in learning more about hormonal contraceptives, IUDs, barrier methods, voluntary surgical sterilization (VSS) and sexually transmitted diseases (STDs). Almost all wanted to learn about considerations in providing contraception to different age groups and about half said they would like to have training on reproductive anatomy and physiology.

The gynecologists reported that they experienced a number of problems when providing contraceptives to clients. In the case of IUD clients, they encountered bleeding, expulsion of the device and lengthy menstrual periods leading to anemia. In the case of combined oral contraceptives (COCs), they found that women often forgot to take the pills, resulting in missed periods. In the case of progestin-only contraceptives, they were concerned by changes in the menstrual cycle and unusual spotting and bleeding. In many cases, the practitioners' knowledge of indications and contraindications for various methods and their management of side effects were found to be incorrect. In addition, ob-gyns thought that condoms are ineffective, but this appears to be due in large part to inadequate counseling when condoms are given to clients.

2. The Role of Gynecologists and other Medical Staff in SVPs

At a time when the government is seeking to retrain specialists working at the PHC level as GPs, the focus groups sought to explore how gynecologists saw the role of internists, pediatricians and mid-level staff in providing RH services.

In discussing the role of internists, about a third of the gynecologists thought that there was no role for them at all and others even observed that internists hamper the prescription of hormonal contraceptives – although they did not specify why. The only ob-gyns who were not opposed to a role for internists were those who had participated in RH training courses together with internists. About half the gynecologists weren't opposed to internists providing *counseling*, after appropriate training.

The gynecologists saw the nurses' role as consisting largely of counseling. Prescription of hormonal contraceptives would be entrusted only to those who had received RH training and just one specialist considered that nurses could insert IUDs. That lone specialist already allows midwives working at the PHC level to insert IUDs – even without the benefit of formal training. The gynecologists thought there was a role for them in the transition to GPs to help train nurses and midwives to insert and remove IUDs and to share their experience in the field of RH services.

3. Attitudes of the Population and Ob-Gyns to Contraceptive Methods

The gynecologists said that their clients' preferred contraceptive methods, in order of choice, were the IUD, then the injectable and, in third place, oral contraceptives. In terms of patterns of use among their own clients, they reported that about 50-60 percent use IUDs, 15-20 percent use COCs and 10-15 percent injectables. They said that clients rarely come for condoms or VSS. Approximately a third of the ob-gyns counsel clients on VSS, all of them refer for the service and a few actually perform the procedure themselves.

The ob-gyns thought that the IUD is the best method for rural populations, with VSS as a second choice. Only in Kuvasay Rayon did the specialists mention hormonal contraceptives as potentially useful for this group. Given high rates of anemia, however, they would prefer to use IUDs less frequently. They would like to prescribe COCs more often, but supplies are unreliable and the price in drugstores is unaffordable for most people. For women who have relative or absolute contraindications to pregnancy, ob-gyns recommend VSS rather than IUDs.

The specialists had insufficient knowledge of the advantages and disadvantages of the different contraceptive methods, although those from Kuvasay were more knowledgeable.

4. Who Makes the Decision about Contraceptive Use

In general, the gynecologists thought that the doctor – rather than the client – should choose the method of contraception a couple will use, although the specialists in Oltiarik Rayon were unanimous in thinking that the woman should choose her own method. All the ob-gyns said that if a woman wanted one method but they thought another method would be more appropriate, they would recommend the one they thought was suitable. They would not leave the decision to the client herself. When pregnancy is contraindicated, threatening the life of the woman, all the participants said that the physician should decide whether the woman should have children or not. Thus, it seems that gynecologists' practices are still far removed from current international consensus that the client should receive her method of choice unless it is clearly contraindicated.

In response to a question about quotas for IUD insertion, the gynecologists said there was no such practice at this time, owing to the shortage of contraceptives.

The participants were aware of many contraindications to IUD-use, citing anemia, pelvic inflammatory disease, STDs, anomalies in genital development, cancer or pregnancy. In response to a question about how they would handle a situation where they suspected an IUD client had an STD, all the participants said they would treat the STD and not insert an IUD. In a similar situation involving a client with anemia, they said they would treat the anemia and then insert an IUD and, if the woman had an IUD in place, they would remove it.

B. Results of the Multiple-Choice Questionnaire

Overall, the 26 gynecologists who took the multiple-choice test scored an average of 66 percent, ranging from 24 to 100 percent. Areas where the physicians' knowledge was strong and where it was weak are presented in Table 3 below. Annex 3 provides average scores for each question.

Table 3: Areas of RH where Ob-gyns had Strong Knowledge and Weak Knowledge, based on the Multiple-Choice Questionnaire (N = 26)

Topic	Areas of Strong Knowledge	Areas of Weak Knowledge
Reproductive Health (RH) and Counseling		The concept of RH Who should choose which contraceptive method to use
Reproductive Anatomy and Physiology	Almost all topics	
Combined Oral Contraceptives (COCs)	Management of forgotten pills Some COC side effects	Contraindications to COCs How to take COCs Use of COCs for emergency contraception
Progestin-Only Contraceptives (POCs)	How POCS work	Contraindications to POCs
IUD	Contraindications Side effects	How the IUD works When it can be inserted How long an IUD can be used
Barrier Methods	Advantages of condoms Disadvantages of spermicides	
Lactational Amenorrhea Method (LAM)		Under what conditions LAM is effective
Natural Family Planning (NFP)	Knowledge of NFP methods For whom NFP is appropriate	
Voluntary Surgical Sterilization (VSS)	For whom VSS may be appropriate	Disadvantages of vasectomy
Sexually Transmitted Diseases (STDs) and HIV/AIDS	How to protect against HIV/AIDS Identification of STDs without laboratory diagnosis	
Infection Prevention	Main infection prevention techniques	Chlorine-use for disinfection

Strong knowledge is defined as an average score of 80 percent or higher among all the ob-gyns; weak knowledge is defined as an average score of 50 percent or below.

Table 3 shows that the gynecologists need updated information on almost all topics. They had a poor understanding of the concept of reproductive health and most of them considered the choice of method to be in the hands of the doctor, rather than the client. In general, their knowledge of theory was stronger than their practical knowledge. For example, they had a good understanding of reproductive anatomy and physiology, of the different methods of natural family planning and of infection prevention techniques. But they lacked important practical information in many areas, such as who can/cannot take COCs, contraindications to POCs, when an IUD can be inserted and how long it can be used, and under what conditions LAM is effective in preventing pregnancy.

V. Recommendations for Training

This needs assessment indicates that the gynecologists need refresher training on most RH topics. They themselves asked for updates on hormonal contraceptives, IUDs, barrier methods, VSS and STDs as well as on method choice for different age groups. Clearly, there is a need to review the basics of providing each method: advantages and disadvantages; indications and contraindications; how to manage side effects and how to instruct clients in the correct use of the method. There is a special need to review LAM and emergency contraception, as well as proper infection prevention procedures. Even though the ob-gyns provide IUDs more than any other method, they would still benefit from a review of which clients should/should not use an IUD, the time of insertion, how long an IUD may be used, prevention and management of complications, prevention of infections during IUD insertion and removal procedures

Probably the most significant finding to emerge from this assessment is the need to address not only the specialists' knowledge and skills, but also their attitudes. Most of them still regard the choice of a contraceptive method as a medical decision to be made by the doctor, rather than approaching it from the client's perspective, giving them their method of choice except when contraindicated. Related to this is the ob-gyns' interest in learning more about which contraceptive methods are most appropriate for which age groups. All of these issues imply a strong focus on clients' rights and the basic steps of counseling.

Annex 1. Focus Group Discussion Guide

General Information

1. Have you ever attended a short course on reproductive health and, if so, when?

   When were you last trained on how to insert IUDs? Which organization conducted the training and when?

2. What additional knowledge in the field of reproductive health would you like to have? Which topics would be of special interest?

3. Which topics do you think we should cover in our training that would be useful for your work in the future?

4. In your experience, which complications occur most often with the different contraceptive methods – IUDs, pills, injectable contraceptives and condoms?

The Role of Gynecologists and other Medical Staff in SVPs

As you know, we are moving toward having a General Practitioner (GP) in each SVP. It will take some time before GPs become fully qualified, especially in the field of reproductive health care. We would like to ask your opinion about certain issues relevant to the transition to GPs.

5. What role do you see for internists in providing RH services?

   - What can they do? Or what would you allow them to do in the RH field and why?

   - What would you <u>not</u> allow them to do and why?

6. Is there a role for nurses in providing RH services?

   - What can they do? Or what would you allow them to do in the RH field and why?

   - What would you <u>not</u> allow them to do and why?

7. How can you, as a gynecologist, help GPs, midwives and nurses to start providing – or broaden their role in providing – RH services.

Gynecologists' Attitude toward the IUD

8. What proportion of the clients you see each day or each week receive each of the following methods:

   - IUDs

   - Pills

   - Injections

   - Barrier methods

   - Sterilization

9. In your opinion, is it appropriate that this percentage of women use _____*(the most used method--and then go through each method)*?

Would it be better if more people used another method? If so, which of the methods listed below? And in what proportion to current use of the method:

   - IUDs

- Pills
- Injections
- Barrier methods
- Sterilization

10. Is there a percentage of women who should use one or another method? (In other words is there a directive from above concerning how many people should use certain methods of contraception?)
11. What is your role in providing VSS? What do you do?
    - Refer the patient to another provider
    - Counsel the patient
    - Perform the sterilization yourself
    - Other

Attitudes of the Population and Ob-gyns to Contraceptive Methods

12. What is your attitude toward different contraceptive methods?
13. In your opinion, what is the best contraceptive method for rural people and why?
14. Now, let's talk about the advantages and disadvantages of each method.

What are the advantages and disadvantages of:

- Oral contraceptives
- Injectable contraceptives
- IUDs
- Barrier contraceptive methods
- Natural contraceptive methods

15. What do you think is the favorite method among women?

Who Makes the Decision about Contraceptive Use?

16. Do you ever face the problem of a woman who wants to use one contraceptive method, but you think another method would be more suitable for her? If so, what do you do in such cases?
17. Who do you think should make the choice of the contraceptive method to be used – the woman or the physician?
18. Under what circumstances should a physician make the decision about whether a woman should have children or not?

Contraindications and Clinical Steps in Cases of STDs or Anemia

There are several contraindications to using IUDs. Please list some of them.

19. If you suspect that a woman might have an STD but you are not sure, what would you do? Would you insert an IUD or not?

20. If you think that a woman has anemia, what would you do?

Thank you very much for taking the time to participate in this discussion!

Annex 2: Multiple Choice Questionnaire

Reproductive Health and Counseling

1. What does the concept of reproductive health care mean to you?

   A. Reproductive health care means care for those of reproductive age
   B. Reproductive health care ensures the correct use of contraceptives
   C. Reproductive health care provides care during the whole life cycle
   D. Reproductive health care limits the number of births

2. What is the aim of reproductive health care?

   A. Improving the health of mother and child
   B. STD prevention
   C. Decreasing the number of genital diseases in women of reproductive age
   D. All of the above

3. Who should choose which contraceptive method to use?

   A. Health worker
   B. Client herself
   C. Members of the client's family
   D. All of the above

Female Reproductive Anatomy and Physiology

4. Which of the following are joined to the external female genitalia?

   A. Vagina, cervix, uterus, tubes, ovaries
   B. Cervix, uterus, tubes, ovaries
   C. Uterus, tubes, ovaries
   D. Tubes, ovaries

5. Which hormone is produced during the first phase of the menstrual cycle?

   A. FSH (follicle stimulating hormone)
   B. Luteinizing hormone
   C. Prolactin
   D. Folliculin

6. How can the process of ovulation be observed?

   A. Through observation of the menstrual cycle
   B. Through observation of changes in the breasts
   C. Through observation of basal body temperature
   D. Only through analysis of hormones in the blood

7. What changes can be observed in the uterus during the first phase of the menstrual cycle?

   A. Proliferation
   B. Secretion
   C. Desquamation
   D. Regeneration

Combined Oral Contraceptives (COC)

8. For which of the following symptoms must a woman taking COCs see a doctor as soon as possible?

   A. Acute lower abdominal pain or pelvic pain
   B. Acute headache, dizziness, general lethargy
   C. Acute pains in the legs
   D. All of the above

9. Which of the following are indications for using COCs?

   A. All women who have been counseled and who wish to use a highly effective contraceptive method
   B. Breastfeeding mothers up to six months after delivery
   C. Women who have had hepatitis
   D. Women who want to be protected against STDs

10. Which of the following are contraindications for using COCs?

    A. Women with genital tract bleeding of unknown origin
    B. Breastfeeding mothers with children over six months old
    C. Women who have a family history of cancer of the reproductive organs
    D. Women with anemia

11. When a woman wants to start using COCs, when should she take the first pill?

    A. First day of the menstrual cycle
    B. In the first seven days of menstrual cycle
    C. Right after menstruation ends
    D. At any convenient time

12. What are the rules for taking COCs?

    A. Take pills at regular intervals
    B. If a woman needs contraception, she can use COCs for a long period of time without a break
    C. If a woman forgets to take one or two pills, she should stop taking COCs
    D. If a woman is sure she is not pregnant, she can start taking pills any day of her menstrual cycle

13. If a woman forgets to take one or two pills, what should she do?

    A. Continue to take the pills as usual and not worry
    B. Throw away the one or two missed pills, and continue to take the COCs
    C. Stop taking the pills till her next menstrual period
    D. Take two pills for a couple of days (to make up for the number of missed days) and then continue as usual

14. Which of the following are side effects of COCs?

    A. Hepatitis and visual impairment
    B. Nausea and pain in the breasts
    C. Acute thoractic pain and breathlessness
    D. Allergic reaction

15. Which of the following groups are at significant risk of complications if they use COCs?

    A. Sexually active teenagers
    B. Women over 35 years old who smoke

C. Women with diabetes (without vascular problems and who have had diabetes for less than 20 years)

Progestin-only Contraceptives (POCs)

16. What are the side effects of progestin-only contraceptives?

    A. Hepatitis or compromised liver function
    B. Acute headaches (migraine)
    C. High blood pressure
    D. Changes in the menstrual cycle

17. How do POCs work?

    A. If POCs are taken, amenorrhea prevents pregnancy
    B. If POCs are taken, ovulation slows down, there are changes in the lining of the uterus and the cervical mucous thickens
    C. POCs affect the hormonal content of the blood
    D. POCs slow down the spermatozoa

18. Before administering Depo Provera, which of the following conditions should be ruled out?

    A. Unknown vaginal bleeding
    B. Cardiovascular disease
    C. History of STDs
    D. Thromboembolic disorders

19. What are the contraindications for using POCs?

    A. The same as for COCs
    B. Genital tract bleeding of unknown origin and pregnancy
    C. Very young women
    D. Women with cancer of the uterus

20. What are the advantages of using POCs?

    A. Use is not related to intercourse
    B. Can be used by breastfeeding mothers
    C. Can be used by women over age 35 who smoke
    D. Regulate the menstrual cycle

21. How often are Depo Provera injections administered?

    A. Every month
    B. Every 2 months
    C. Every 3 months
    D. Twice a year

Intrauterine Devices (IUDs)

22. How does the copper on IUDs prevent pregnancy?

    A. Slows the movement of spermatozoa from the vagina to the fallopian tube
    B. Blocks the fallopian tubes, so that the fertilized ovum cannot reach the uterus
    C. Stops ovulation
    D. All of the above

23. When can an IUD be inserted?

A. During menstruation
B. Only after menstruation ends
C. At least 48 hours after delivery and not less than 4-6 weeks after delivery
D. Immediately after abortion, whether or not there is a pelvic infection

24. The Copper T380A IUD should be removed at least every:

A. 3 years
B. 5 years
C. 8 years
D. 10 years

25. IUDs should not be used by women who:

A. Are breastfeeding
B. Have recently had an STD or STI
C. Have more than three children
D. Are over 35 and smoke

26. If a woman who has an IUD cannot feel the strings, she should:

A. Not worry, because they sometimes disappear into the uterus
B. Check the strings again after the next menstrual period—but don't do anything before that
C. Check them every day until they reappear
D. See a physician immediately, as an IUD can be expelled, placing the woman at risk of pregnancy

27. Which of the following are side effects of the IUD?

A. Excessive and protracted menstruation
B. Fever or chills
C. Purulent discharge from the vagina
D. Dysuria

Natural Family Planning (NFP)

28. NFP methods include:

A. Lactation Amenorrhea Method (LAM)
B. Sympto-thermal method
C. Calendar method
D. All of the above

29. Under which of the following circumstances is LAM effective?

A. Breastfeeding during the first 6 months after delivery, accompanied by menstruation
B. The whole breastfeeding period
C. Breastfeeding during the first 6 months after delivery, accompanied by amenorrhea
D. Breastfeeding with an 8-hour break at night

30. Who can use NFP?

A. Only nulliparous women
B. Women with irregular menstrual cycles
C. Women of reproductive age
D. Women who have two or more sexual partners

31. Which of the following is <u>not</u> an advantage of NFP?

A. No side effects
B. Economical
C. Clients must understand reproductive physiology
D. All of the above

Barrier Methods and STDs

32. What are the main advantages of condoms?

A. They are effective immediately
B. Absence of side effects
C. Low cost
D. Protect against STDs and genital tract infections

33. What are the disadvantages of spermicides?

A. Possibility of burning or itching in the vagina
B. Possible side effects due to the estrogen
C. Impact on breastfeeding
D. The need for a pelvic examination before starting the method

34. How can a sexually active woman protect herself from HIV/AIDS?

A. Use a condom if her partner may have AIDS
B. Use condoms every time she has intercourse
C. Change partners no more than once a month
D. Have no more than two partners at the same time

35. What are the possible signs of STDs in women?

A. Vaginal discharge
B. Genital ulcers
C. Lower abdominal pains
D. All of the above

36. How can one identify STDs without a laboratory analysis?

A. By taking a blood sample for analysis
B. By measuring blood pressure and temperature
C. Examining the genitals and asking the patient a number of questions
D. Diagnosis of STDs is not possible without laboratory tests

Age Considerations

37. Which of the following methods can be used by women with thromboembolic problems who are over age 35?

A. COCs
B. POCs
C. IUD
D. POCs and IUD

38. How should low dose (30-35 microgram) COCs be taken as a method of emergency contraception?

A. 2 pills in the first 72 hours and 2 more pills in the next 12 hours
B. 4 pills in the first 72 hours and 4 more pills in the next 12 hours
C. 6 pills in the first 72 hours and 4 more pills in next 12 hours

D. 2 pills every 4 hours for a 24 hour period

Voluntary Surgical Sterilization (VSS)

39. Which of the following is the most important fact about VSS?

A. Only women who have six or more children can receive VSS
B. It is a simple surgical operation, which does not require long hospitalization
C. It is a permanent and irreversible contraceptive method
D. Spousal consent is required before the procedure is carried out

40. Which of the following is a disadvantage of vasectomy?

A. Highly effective
B. Effective immediately
C. Simple operation
D. Absence of long-term side effects

41. For which women is tubal occlusion appropriate?

A. Those who are unsure if they want more children.
B. Those who do not yet have children
C. Those who have a health condition making pregnancy dangerous
D. Those whose husbands have advised them to have this operation

Infection Prevention

42. How should you disinfect used instruments such as a gynecological speculum or forceps?

A. By soaking them in 0,5% chlorine solution for 10 minutes
B. By soaking them in 0,5% chlorine solution for 1 hour
C. By soaking them in 0,1 % chlorine solution for 10 minutes
D. By soaking them in 0,1 % chlorine solution for 1 hour

43. Which of the following prevent infection?

A. Washing hands and using gloves
B. Disinfection, washing and sterilization (high level disinfection) of instruments
C. Use of antiseptic solution on the skin before administering injections
D. All of the above

44. What is the correct way of dealing with used disposable needles and syringes?

A. Put the cap on the used needle and throw the needle and syringe into the waste box
B. Bend or break the needle to avoid possible injury
C. Place the syringe and needle in a safe container, without capping the needle
D. Wash the needle with water and take it off the syringe before discarding it

Annex 3: Ob-gyns' Average Scores on the Multiple-Choice Questionnaire

(N = 26)

Question No.	Topic Area	% Correct
1	Reproductive health counseling	32
2		68
3		45
4	Female reproductive anatomy and physiology	59
5		88
6		100
7		88
8	Combined oral contraceptives	55
9		82
10		35
11		55
12		24
13		95
14		80
15		45
16	Progestin-only contraceptives	59
17		82
18		50
19		82
20		64
21		55
22	Intrauterine devices	100
23		36
24		45
25		45
26		81
27		68
28	Natural family planning	82
29		88
30		47
31		94
32	Barrier methods	65
33		82
34		100
35	Sexually transmitted diseases	82
36		77
37	Age Considerations	82
38		41
39	Voluntary surgical sterilization	36
40		82
41		18
42	Infection prevention	68
43		41
44		82
45		68
	Average Score	**66%**